Virginia Medical Interpreter Training Grants Program

Monthly Verification of Community Service

I, _____, authorize my supervisor to provide the community service information requested by the Virginia Department of Health, Office of Minority Health and Public Health Policy (VDH, OMHPHP). A copy or facsimile of this authorization may be accepted as an original.

_____ _____ _____

Signature of Grant Recipient | Last four digits of your Social Security Number | Date

_____ has applied for or is a participant in the Virginia Medical Interpreter Training Grants Program administered by the VDH OMHPHP. Participants are required to receive monthly certification from the community service site of the applicant's volunteer status. Please complete the following section on the last day each month and return it to the address or fax number listed below. Thank you.

Name of Community Service Site: _____

Site Address: _____

_____

Email Address & Phone Number _____

Please note & initial the number of hours that have been volunteered each month:

Date of Service	Location	Type of Service Provided Agency	# People Assisted: (Individuals or groups)	No. of Hours	Agency Rep. Initial
Example: 1/10/2009	Roanoke	Outpatient CHC	5 – individual consults	4 hours	
			Total Hours		

_____ _____

Name of Certifying Official | **Title**

_____ _____

Signature of Certifying Official | **Date**

The certifying official must Fax and send by US Mail the completed initialed and signed form by seventh of each month to the Virginia Medical Training Grants Program to the following:

Blue Ridge Area Health Education Center
Susannah Lepley
MSC 9009, James Madison University
Harrisonburg, VA 22807
Fax: 540-568-3172
Phone: 540-568-3383